The Physician and Comprehensive Health Planning

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COMPREHENSIVE HEALTH PLANNING (Public Law 89-749) enacted by the 89th Congress in 1966 is one of the most important single pieces of legislation affecting public policy in health in the history of the United States. Although more than a score of other health and health-related laws were passed by the Congress that year, including Medicare, Medicaid and Regional Medical programs (which received more attention and public debate), the so-called Partnership for Health Act will probably have a greater effect on the total spectrum of future health care services, organization, financing, distribution and delivery than all of the others combined. Those physicians who tend to look upon the Medicare law as the turning point in public policy regarding health are merely viewing a small arc of the wide circle of events which already have been and are yet to be generated as a consequence of this legislation which passed virtually unnoticed and unheralded in the plethora of health legislation of the '60s.

The Comprehensive Health Planning and Public Health Service Amendments of 1966 did indeed formulate the principles for the design of a framework around which new directions and courses of action would be developed for the health care of the American public. But, more, it introduced new concepts and structures which would assure the broadest voluntary involvement of community forces and institutions in its implementation. If there are any doubts regarding the intent of Congress, a single sentence in the preamble to the law should dispel them. It reads:

> "The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living."

Although events and experience over the past three years have raised questions and created frustrations concerned with the nature of the "partnership," the law has at least produced the beginnings of an alliance among the various elements and components of the private and public sectors and the various levels of local, state and federal governments. This amalgam is beginning to yield evidence of cooperative and coordinating efforts to "plan together" and to "plan comprehensively" in order to be concerned with all of the problems which affect the "health environment" of the public. Thus, for the first time, all factors relating to health are being approached as part of a total problem rather than as fragmented or single parts existing by themselves. To comprehend how all-encompassing this piece of legislation is, and how closely its activities are intertwined with the professional obligations and social responsibilities of the medical profession, one need only realize that the areas of personal health services, health facilities, environmental health, mental health and manpower are included in the scope of responsibilities of the law. Its greatest innovation, however, rests in the fact that, for the first time, it accords to the public, as consumers, a potent voice in the planning decisions to be made.

Comprehensive health planning therefore provides the meeting ground where representatives of the health care professions come together with representatives of the public not as patients but as

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peers in the planning process. Although the concept of planning is not a new one, the term *planning process* has taken on new meaning to the individuals, organizations and communities engaged in this process, since many of those involved bring to the planning arena a range of experience ranging from minimal to maximal exposure to and understanding of the issues with which they are confronted. For physicians, particularly, the process offers opportunities for contributing to community efforts to identify health problems, to assist in securing appropriate and valid information about such problems, to aid in establishing broad goals and specific objectives with reference to alternative solutions, and to evaluate the results of efforts made to deal with them. Like the others whose opinions they will share, physicians must begin to look at old problems in a new way, to reexamine existing patterns, to evaluate the evidence brought to their attention, and to consider or embark upon new ways of doing things. They will be involved in a never-ending self-renewal cycle of events which must take into account all the community resources and facilities and the coordination of such resources, as well as the creation of new approaches and mechanisms where they are needed for resolving the problems under study.

The basic implementing sections of comprehensive health planning legislation illustrate the wide scope of activities and responsibilities with which program participants and the total community must become familiar. They are:

Section 314(a): Statewide Comprehensive Health Planning—which provides for the establishment of a single state agency to develop a comprehensive health plan for the state to provide comprehensive health services, both public and private. The agency in California is the State Department of Public Health. Its advisory body, the State Health Planning Council consists of providers and consumers, with the latter constituting a majority.

Section 314(b): Areawide Comprehensive Health Planning—which provides federal funds to public or non-profit private agencies to engage in organizational and comprehensive health planning efforts for a given geographic area of the State. Nine such geographic areas have been designated by the State Health Planning Council in California.

Section 314(c): Grants for Training, Studies and Demonstrations—which provides federal funds for programs which are intended to develop new kinds of persons to meet manpower needs of comprehensive health planning agencies, both statewide and areawide.

Section 314(d): Block Grants for Comprehensive Health Services—which provides for the elimination of the traditional funneling of federal funds to state public health and mental health departments through categorical grants, and establishes a block grant system.

Section 314(e): Project Grants for Health Services Development—which provides grants to meet the health needs of the people. Applications for funds must be reviewed and approved by the state agency for conformance with such plans as have been developed by the agency. Final funding decision rests with the federal agency; very few of such grants have been funded in California due to lack of money.

Just as the California Medical Association assumed a leadership role in cooperating with and implementing Public Law 89-239 (Regional Medical Programs for Heart Disease, Cancer and Stroke), it took the initiative in calling the attention of physicians to the potentials for service and their professional contributions in implementing the provisions of Public Law 89-749. Even before the program got off the ground in California, the California Medical Education and Research Foundation of the California Medical Association sponsored (in November, 1967) a 14-state regional conference on "Future Directions and Decisions in Medical Care." This conference, which was devoted to a discussion of the law and to the role of the medical profession was followed in July, 1968, by a regional conference on the "Planning Process" and, in November, 1969, by a regional conference which concerned itself with the "Progress, Problems and Perspectives" of the legislation.

In California the State Health Planning Council (originally constituted with 13 members and later expanded to a 21-member group) supervises the comprehensive health planning functions of the State Department of Public Health. It has developed and adopted guides and policies for comprehensive health planning activities by areawide agencies and has designated nine geographic areas for health planning, eight of which have been funded to date.* Committees of the State Health Planning Council have been appointed and charged

*The areas, and the cities of their headquarters, are: North Coast, Eureka; Superior California, Chico; Golden Empire, Sacramento; Bay Area, San Francisco; North San Joaquin, Stockton; Central California, Fresno; Mid-Coast, Salinas (not yet funded); Southern California, Los Angeles; San Diego-Imperial, San Diego.

with responsibilities in the fields of personal health services, environmental health, health facilities, health manpower, and health information systems. Special task forces have been established to deal with specific problems such as manpower, emergency medical care and outpatient care. A variety of liaison activities have been initiated to help assure the coordination of efforts of statewide private and public agencies. These include Air Resources Board, California Commission on Aging, Office of Economic Opportunity, Department of Alcoholic Beverage Control, water resources and other departments and agencies of state government. The incorporation of separate legislatively established committees, previously responsible for Hill-Harris (Burton) allocations and for mental retardation activities into comprehensive health planning, has resulted in further coordination of statewide planning efforts. The recent enactment of California's AB 1340 provides a voluntary basis for area-wide planning of facilities. It has resulted in giving areawide comprehensive health planning agencies additional authority and responsibilities with regard to licensing hospitals and facilities. This role was formerly carried out by the Voluntary Health Facilities Planning group but in 1969 this activity was merged to Comprehensive Health Planning. Guides for implementation of this responsibility were approved by the State Health Planning Council in January. Now in development is a state plan for health and a work program which will establish goals and priorities for statewide planning efforts.

In all of these activities, county medical societies and their members have played a most impressive role by bringing together representatives of a cross-section of their communities for the purpose of establishing county as well as areawide committees to carry out the intent of Public Law 89-749. It is largely due to their efforts and to the encouragement given to them by the California Medical Association that California has acted so quickly and progressed so far in this program. It is expected that physicians will continue to support these efforts, in the realization that local community planning is the key to the development of a rational state plan for health. There is universal recognition of the fact that, for the first time, comprehensive health planning provides communities with the opportunity to plan on the basis of local needs and local assessments of the health problems in their respective areas. If this effort should fail, they should have no doubt that decisions will be made for them by other legislative actions.

The efforts in California thus far have been largely concerned with the organizational phase of implementing P.L. 89-749. Nevertheless, significant beginnings have been made in the planning process itself; problem areas are being identified, information is being collected and evaluated, plans are being formulated and goal and priorities are in the formative stages of development. There are yet a number of problems to be resolved, but the evidence on hand is that California is forging ahead. The problems that exist vary from one area to another, and some of them will take time and patience to resolve. Some of them will find solutions locally; some will have to be resolved by the State Health Planning Council; and some must look to legislative changes in the law by Congress for solution. Intrinsic and extrinsic factors and relationships have created uncertainties, frustrations and even head-on collisions with other health programs and activities which have not as yet been assigned to or coordinated with comprehensive health planning by the Congress. Lacking are federal administrative policies and firm guidelines relating to comprehensive health planning, the health programs of the Veterans Administration, Regional Medical Programs, Office of Economic Opportunity, Model Cities and Indians Affairs, for example.

Whether some or all of these programs eventually come within the purview of comprehensive health planning activities or remain as individual entities is perhaps less important at this time than the need for all programs to accept the responsibility of developing liaison and cooperative relationships with a program which is committed to stimulating and conducting comprehensive health planning for all segments of the American public. There appears to be no reason why the capabilities and commitments of each program cannot be utilized to achieve the intent of Public Law 89-749 whose purpose is to create "an environment which contributes positively to healthful individual and family living."

Therefore all physicians in the private practice of medicine can aid in these efforts in behalf of their patients and their communities. This will give demonstrable evidence of the medical profession's support of the concept of voluntary comprehensive health planning. The experience in California in the past three years must be taken as an earnest of that support.